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Association

Final Report

Ad Hoc Committee on Language Proficiency

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Background

In 2014, in response to concerns from state licensing boards about the English proficiency skills of internationally trained audiologists and speech-language pathologists (SLPs), ASHA's International Issues Board (IIB) completed a review of ASHA certification requirements and submitted a request to the ASHA Board of Directors (BOD) requesting that they increase the passing scores for English proficiency for international applicants for the ASHA Certificates of Clinical Competence (CCCs). The intent of the IIB was to ensure that all international applicants receiving their CCC from ASHA could provide the same quality of clinical services expected of graduates from ASHA-accredited programs in the United States.

Subsequent to this request, ASHA's Council for Clinical Certification (CFCC), the Multicultural Issues Board (MIB), the IIB, and the ASHA BOD discussed several relevant issues. In January 2017, the ASHA BOD established the Ad Hoc Committee on Language Proficiency (hereafter, "the Committee"), charged with (a) defining *language proficiency;* (b) providing recommendations to the BOD regarding the feasibility of establishing a required level of language proficiency for clinical practice; and (c) identifying mechanisms to assess applicants' language proficiency skills, including spoken, written, manually coded language use.

The Committee comprised invited members having one or more of the following qualifications:

- Is a practicing bilingual clinician (Spanish language speaker)
- Is a practicing bilingual clinician (other language speaker)
- Is an internationally educated clinician
- Has state board licensing expertise
- Has professional translation experience, particularly related to health care (optional Speech-Language Pathology Assistant [SLPA] background)
- Is a clinician who has worked internationally
- Is an academician from a communication sciences and disorders (CSD) program with a bilingual/multicultural focus
- Is an academician from a CSD program with no bilingual/multicultural focus
- Is an ASHA-certified audiologist
- Is an ASHA-certified SLP
- Is a staff ex officio
- Is ASHA's Vice President for Planning (who serves as BOD liaison)

The Committee addressed each of the three aspects of its charge. The Committee determined that *language proficiency* can be defined, proposed a set of recommendations related to a required level of language proficiency for communicative effectiveness in the clinical practice of audiology and speech-language pathology, and identified current best options for assessing language proficiency.

Defining *Language Proficiency*

Defining *language proficiency* for our professions required considerable deliberation of a number of complex but related issues, including the need to account for the variability inherent to different languages, the desire to denote the distinction between *language proficiency* and *English proficiency,* and the importance of communicative effectiveness in interpersonal and professional interaction. There was discussion about the need to distinguish between (a) the knowledge required for providing quality

services and (b) the skills needed to conceive and produce what is necessary in practice to facilitate effective communication with individuals who have speech, language, and/or hearing disorders.

Defining *language proficiency* requires describing what is necessary to speak, understand, use, or perform appropriately in a given language. Both expressive and receptive language skills must be evaluated across the four domains of speaking, listening/understanding, reading, and writing—which, at a more detailed level, include other components (e.g., phonology, morphology, syntax, semantics, and pragmatics) that will vary across languages. Thus, the Committee opted for a functional definition of *language proficiency* with application across most languages.

> **Definition: *Language proficiency* is defined as effective receptive and expressive language skills in both written and spoken modalities.**

Requiring Language Proficiency for Clinical Practice in Audiology and Speech-Language Pathology

Considerations Related to Equity and Impact

The Committee agreed that issues related to equity as well as to the potential impact and application of a definition required special attention. Two foundational assumptions guided Committee deliberations and conclusions. A definition of *language proficiency* was a prerequisite to tackling any of the issues related to bilingual practice, and any related recommendations from this Committee must strike a balance between (a) the need for diversity, cultural competence, and international exchange and (b) the requirement that clinicians provide effective, quality services to their clients/patients/students.

A definition of *language proficiency* should not, in and of itself, bar well-qualified professionals from providing needed services. The proposed definition of *language proficiency* does not adversely impact ASHA's efforts related to international engagement, which ASHA seeks to enhance through its *Strategic Objective #7* (SO7), "Enhance international engagement." Indeed, ASHA has established partnerships and collaborations to:

- promote an exchange of perspectives across cultures
- enrich research with data and articles by authors from outside the United States
- compare service delivery models from different regions of the world
- provide volunteer opportunities to build skills and capacity in resource-limited countries
- advocate for our professions and raise their profile worldwide
- develop and disseminate resources and tools globally, and
- share learning methodologies used in other countries to treat communication disorders in multicultural and multilingual populations.

A primary focus of SO7 is to position ASHA as a global resource for building capacity without the intent to convert other countries to U.S. standards and systems. Thus, initiatives avoid any underlying messages of elitism or required assimilation. However, because the language proficiency standard proposed here applies only to those audiologists and SLPs seeking to provide speech-language and/or hearing services in the United States, including Commonwealths and U.S. Territories, it is unlikely to adversely affect ASHA's efforts related to international engagement.

The definition of *language proficiency* should also not negatively influence ASHA's strategic efforts to attract more service providers from culturally and linguistically diverse backgrounds. There is an urgent

need for bilingual service providers; it is critical for all ASHA members to competently address cultural and linguistic influences on service delivery outcomes for all clients/patients/students. ASHA's *Strategic Pathway to Excellence* (ASHA, n.d.) has two strategic objectives that relate directly to language proficiency: *Strategic Objective #6* (SO6), "Increasing the diversity of the membership" and *Strategic Objective #8* (SO8), "Increasing members' cultural competence." SO6 is focused on increasing the number of men, individuals from underrepresented racial and ethnic backgrounds, and bilingual service providers. SO8 relates to cultural competence as an integral component of clinical competence. Changes in both of these *Strategic Objectives* are sorely needed to (a) help provide the diversity of perspective in discussions, deliberation, and decision making in the discipline of CSD and (b) ensure culturally effective and relevant outcomes. ASHA policy and practice must provide support for the attainment of these Strategic Objectives.

Another consideration is that language proficiency and intelligibility of accented speech are interrelated; however, they are not necessarily the same. Information about students and professionals with accents is provided in detail in the *Students and Professionals Who Speak English With Accents and Nonstandard Dialects: Issues and Recommendations* (ASHA, 1998) and *The Clinical Education of Students With Accents* (ASHA, 2011).

Finally, an official definition of *language proficiency* ensures that all clients/patients/students have access to the same level of quality service delivery by ASHA-certified professionals. This consideration is affirmed in the ASHA Code of Ethics in requirements that ASHA members provide services competently (Principle of Ethics I, Rule A) and do not discriminate in the delivery of professional services (Principle of Ethics I, Rule C).

Ensuring Consistency of Service Delivery

A definition of *language proficiency* must ensure the requisite skills for providing a consistent level of service delivery for all clients/patients/students served by all ASHA-certified professionals. Thus, it is critical that ASHA hold all applicants seeking ASHA Certification of Clinical Competence in Audiology (CCC-A) or in Speech-Language Pathology (CCC-SLP) to the same standard of language proficiency for clinical practice, whether they graduate from academic programs accredited by the Council on Academic Accreditation of Audiology and Speech-Language Pathology (CAA), non–CAA-accredited programs, international programs, or programs where English is or is not the language of instruction. That requisite level of service requires communicative effectiveness in varied professional roles. Thus, any definition of *language proficiency* for practice in the United States must imply that the use of an effective level of proficiency in English is to account for those job requirements that must take place in English. Audiologists and SLPs working in the United States need to collaborate with other professionals, review and write reports, review and apply evidence and research findings, communicate with administrators, and understand and comply with legal requirements. These activities typically are carried out in the United States in English, which is why the ASHA standards for clinical certification already require English proficiency. A review of the *Scope of Practice in Audiology* (ASHA, 2018) and the *Scope of Practice in Speech-Language Pathology* (ASHA, 2016b)—and careful consideration of the functions that clinicians carry out—confirmed that English language proficiency is required to do the work of a certified audiologist or SLP. In addition, clinicians must provide for appropriate services to address the specific language needs of clients/patients/students.

All clients/patients/students are entitled to the same level of quality service delivery by ASHA-certified professionals, regardless of the language(s) they speak/use, and bilingual service providers must have additional knowledge and skills. On the Association's online Practice Portal, ASHA documents the

knowledge and skills needed to provide bilingual service delivery. Clinicians providing services in more than one language need to collaborate with other professionals, review and write reports, review and determine application of research findings, communicate with administrators, understand and comply with legal requirements, and so forth, and must have the linguistic proficiency in the client/patient/student language(s) to conduct assessment and treatment strategies. These strategies require abilities to

- select and interpret culturally and linguistically appropriate assessment materials, tools, and methods;
- instruct and assess the client/patient in direct clinical techniques using behavioral, physiologic, and developmental measures;
- select, administer, and interpret standardized self-report measures of communication difficulties and of psychosocial and behavioral adjustment to auditory dysfunction;
- describe normal speech and language acquisition for dual language learners;
- distinguish between communication differences and disorders; and
- provide treatment in the language or mode of communication that best meets the needs of the client/patient/student.

This report includes a recommendation to establish an additional ad hoc committee to define language proficiency for carrying out such tasks in a non-English language.

Manual communication is not addressed as a separate modality, but instead, American Sign Language (ASL) and many other manual modes of communication are considered separate languages and thus should be addressed as requirements for bilingual service delivery. Gallaudet University's American Sign Language Proficiency Interview (ASLPI) thoroughly describes five levels of proficiency for signers as an evaluation of global ASL proficiency. The Committee determined that ASHA does not need to create a new description of *ASL proficiency.*

Current Best Options for Assessing Language Proficiency

Language proficiency definitions and descriptions vary and were widely researched. The Committee debated the need for and potential value of requiring a subjective or universally applied measure to all certification applicants, but doing so seemed excessive and unnecessary because the overwhelming majority of applicants' language proficiency is not in question. One of the most difficult tasks that the Committee faced was operationalizing a measure of language proficiency for clinical service delivery because the responsibility for assessment is distributed across a number of entry points for application at individual academic programs and through current international application processes. Identifying a way to evaluate language proficiency for some groups but not for everyone is complicated further by potential implicit and explicit bias, subjectivity, and inconsistency in ASHA members' understanding of the distinction between language proficiency and accent/dialect usage.

The Committee reviewed the English proficiency standard described in the *2014 ASHA Certification Standards in Speech-Language Pathology* for graduates from ASHA-accredited programs and concurred that it was an adequate baseline for performing the roles and functions detailed in ASHA's *Scope of Practice in Audiology* and *Scope of Practice in Speech-Language Pathology*. However, the level of English proficiency required for international applicants and/or those for whom English was not the language of academic and clinical instruction was deemed inadequate. The Committee determined that an objective evaluation of language proficiency is necessary for international applicants and for students graduating from CAA-accredited programs where English is not the language of instruction.

Ideally, an objective evaluation would measure language proficiency in the context of delivering the professional services required of an audiologist or SLP. Unfortunately, such a measure is not yet available through a known effective and accessible mechanism. The Occupational English Test (OET; Cambridge Boxhill Language Assessment Trust, n.d.) has merit, but current limitations include the lack of availability of a version specific for audiology, limited geographic availability of examination sites, and the use of a variety of dialects of English used around the world that may be confusing for applicants. In addition, there is a need to determine whether the OET scoring is as discriminating in the higher ranges as is needed for making decisions about an individual's ability to use English effectively for clinical practice in our professions.

At this time, the Test of English as a Foreign Language (TOEFL; Educational Testing Service [ETS], n.d.-a, n.d.-b) and the International English Language Testing System (IELTS; IELTS Partners, n.d.-b) are the best options for objectively measuring English proficiency for international applicants. Evidence indicates that both of these measures discriminate English proficiency beyond the academic environment and are correlated to overall language proficiency, a major criticism of their use in the past. Another advantage of both the TOEFL and the IELTS is that concordances have been established for their scores (Manhattan Review, n.d.), and their scores have been evaluated in conjunction with the Common European Framework of Reference for Languages (CEFR; Council of Europe, 1989, 2018a, 2018b; IELTS Partners, n.d.-a; Lim, 2017; Papageorgiou, Tannenbaum, Bridgeman, & Cho, 2015) levels. The CEFR provides a widely used international guideline for describing abilities of foreign language learners. Comparison to CEFR levels allows standards to be readily compared, which makes it possible to consider accepting applicants' scores from either measure. The Committee proposed a definition and description of *language proficiency* that is based on requirements for clinical professional services and that reflects guidelines and levels from the CEFR (2018a, 2018b), the Interagency Language Roundtable (ILR, 2011), and the American Council on the Teaching of Foreign Languages (ACTFL, 2012), all of which identify specific skills that should be demonstrated by proficient speakers.

ASHA's CFCC currently relies on decisions made by the International Commission on Healthcare Professions—which is a division of the Commission on Graduates of Foreign Nursing Schools (CGFNS), an international credentialing organization of graduates for a number of health professions—to determine the qualification of international applicants for ASHA certification. Their current standard for English proficiency for audiologists and SLPs is

- a passing score of 83 and a score of 26 on the spoken section of the TOEFL and
- a score of 6.5 on the IELTS, with a score of 7 on the spoken section.

It is noteworthy that the TOEFL and IELTS scores required by other English-speaking countries are considerably higher (Health & Care Professions Council, 2014), even when they are for professions that are less language intensive than audiology and speech-language pathology (e.g., physical therapy, nursing). The Committee recommends (a) that ASHA approach CGFNS about the critical need to raise their requirements for Audiology and Speech-Language Pathology visa applicants and (b) that the language proficiency scores for ASHA certification be raised (raise the minimum TOEFL Total Score to 105 with at least a 26 on the Speaking and Listening subtests, and raise the minimum IELTS Total Score to 7.5, with at least a 7.5 on the Speaking and Listening segments).

Recommendations

This Ad Hoc Committee on Language Proficiency makes the following recommendations:

1. **Recommendation: That the ASHA BOD approve the proposed definition and description of *language proficiency* as follows:**

   Definition: *Language proficiency* is defined as effective receptive and expressive language skills in both written and spoken modalities.

   Expressive

   Speaking
   Statements are consistently spontaneous and are formulated and expressed clearly and effectively across diverse topics in professional and social/interpersonal contexts.

   Writing
   Written language reflects well-structured organization across diverse topics and levels of complexity, with flexible use of vocabulary.

   Receptive

   Listening Comprehension
   Spoken language is understood in professional and social/interpersonal contexts.

   Reading
   Reading is accurate and independent; the individual comprehends, analyzes, and infers from written language in various styles and formats that include pertinent scientific reports, professional/official documents, and correspondence.

   Dialectal and/or accented variations in any of the above modalities are expected and acceptable in proficient speakers who may occasionally experience difficulty understanding colloquial expressions and idioms and/or whose speech may contain minimal differences that do not alter the communication of the intended message.

2. **Recommendation: That the ASHA BOD encourage the CFCC to hold all applicants for ASHA Certification to the same standard by using the proposed definition of *language proficiency* as the expectation for English proficiency for all applicants.**

   We affirm that the requirements for English speakers graduating from CAA-accredited programs have been largely effective at identifying appropriate communication abilities in prospective audiologists and SLPs. As is noted in the existing requirements, dialectal and/or accented variations of English are expected and acceptable in proficient English speakers.

   The proposed definition of *language proficiency* becomes the standard to which all applicants are held. Prescribing a process for graduates of CAA-accredited programs where English is the language of instruction is unwarranted because that assumes a universally applicable standard that disregards the validity of the inherent variability of English used across regions, populations, and social groups in the United States. We are not requiring formal assessment of any graduates from CAA-accredited CSD programs. The proposed definition incorporates English requirements for graduates of CAA-accredited academic programs and the current operational framework that requires an Academic Program Director and Clinical Fellow (CF) mentor (for SLPs only) to verify an applicant's English language proficiency. Such verification must take place keeping in mind ASHA policy and expectations to ensure nondiscrimination. In addition, to equate the competencies required for English

language proficiency for international applicants seeking ASHA Certification, TOEFL or IELTS scores will serve as confirmation of the applicant's level of language proficiency.

The definition of *language proficiency* should be added as the standard for language proficiency required for both audiologists and SLPs applying for ASHA Certification. The description provides information to integrate into implementation language for the CCCs—specifically for ensuring that the language proficiency of all applicants is comparable to that of graduates of CAA-accredited programs where the language of instruction is English.

3. Recommendation: That applicants from non–CAA-accredited programs and those graduating from academic programs where the language of instruction is not English demonstrate English proficiency through a passing score on the TOEFL or the IELTS.

Language proficiency is the ability to communicate accurately, effectively, and spontaneously in expressive (spoken and written) and receptive (listening and reading) modalities. Widely used tests of English language proficiency that assess skill in each of the four modalities of language (speaking, listening, reading, and writing) include the IELTS, which is based on English as a global language (including English used in North America, Britain, Australia, and New Zealand), and the TOEFL, based on American English.

The IELTS exists in two versions: academic and general. International students can meet English language requirements at most universities with the IELTS academic test; the general test is more oriented toward immigration for employment purposes. The IELTS is jointly managed by three organizations: (1) the British Council; (2) IDP: IELTS Australia; and (3) Cambridge Assessment English. The academic version is a reasonably reliable measure of general language ability as well as a dependable indicator of one's aptitude to understand and produce language for academic purposes. It evaluates four linguistic domains: listening, reading, writing, and speaking. The Listening, Reading, and Writing Segments must be taken on the same day, whereas the Speaking Segment may be taken up to 7 days before or after the other ones.

In addition to its longstanding, widespread use and international availability, a major strength of the TOEFL—particularly for ASHA's purposes—is the fact that it is managed and fully supported by the Educational Testing Service (ETS). The internal and external research available on the TOEFL includes more than 150 peer-reviewed documents describing the psychometric properties (e.g., reliability, validity, factor structure, etc.) and how that research correlates with student admissions and performance as well as with other tests of language proficiency—including the IELTS and the CEFR. These articles, reports, and monographs are available from ETS.

Scores for both the IELTS and the TOEFL have been evaluated in conjunction with the CEFR levels and, therefore, can be readily compared, which makes it possible to consider accepting applicants' scores from either measure. Language proficiency, as described by the Committee, is based on requirements for clinical professional services and reflects guidelines and levels from the CEFR, the ILR, and ACTFL, all of which identify specific skills that are evident in proficient speakers. The Committee has agreed that applicants for certification—whether from CAA programs or from foreign countries—should meet language proficiency levels that are above those that would correspond to scores currently required by CGFNS. Indeed, the scores stipulated by CGFNS for clinicians in audiology and speech-language pathology are lower than the scores stipulated for clinicians in physical therapy, occupational therapy, and nursing—all professions with less intensive language demands. This is inadequate and inappropriate for clinicians in the CSD discipline. It is notable that the TOEFL and IELTS scores required by other English speaking countries are considerably higher. The committee therefore recommends that ASHA require a minimum Total TOEFL score of 105, with at least a 26 on Speaking and Listening Subtests; and a Total IELTS score of 7.5, with at least a 7.5 on the Speaking and Listening segments.

The suggested scores are representative of the description of language proficiency as presented in the Committee's report as well as with descriptions of C1 and C2 language mastery levels deemed proficient in the CEFR. Moreover, they are consistent with requirements in other English speaking countries, for entry into the professions.

The Committee also recommends ongoing evaluation of how effectively the TOEFL and IELTS measures are meeting the association's needs.

4. **Recommendation: That the ASHA BOD encourage CFCC to explore the possibility of a profession-specific English proficiency exam (e.g., OET, ETS, etc.) for determining English proficiency of audiologists and/or SLPs trained outside the United States.**

   An ongoing discussion should continue with the publishers of the OET to determine whether this test, as a profession-based tool, is an effective mechanism for evaluating English language proficiency for audiologists and SLPs trained outside of the United States. It is necessary to determine (a) whether the OET scoring is as discriminating in the higher ranges as is needed for making decisions about the ability of an individual to use English effectively in our professions and (b) whether the dialectal varieties of English pose significant limitations in determining English proficiency for practice in the United States. What also needs to be determined is whether an audiology-specific version of the OET is potentially needed and/or is viable—and whether the number of examination sites will meet ASHA's needs.

5. **Recommendation: That the ASHA BOD encourage the CFCC to lobby CGFNS/Health Resources and Services Administration (HRSA) to adjust the minimal passing scores required for meeting the English proficiency requirement for ASHA Certification for international applicants from non–CAA-accredited programs and/or from academic programs where the language of instruction is not English.**

   The current CGFNS Visa screening system includes an English language requirement and is used to determine eligibility for ASHA Certification. If CGFNS continues to be the mechanism for documenting applicants' ability to meet ASHA's English language proficiency requirement, then the CFCC will need to provide supporting documentation to CGFNS/HRSA to make the necessary adjustments to the scores/exams for both the IELTS and the TOEFL. The recommended increase in test scores better reflects the linguistic demands of our professions and the degree of proficiency described in the proposed definition and description of language proficiency.

6. **Recommendation: That the ASHA BOD establish an ad hoc committee to determine ways to demonstrate proficiency for bilingual service delivery and provide services in languages other than English.**

   All clients/patients/students are entitled to quality service delivery provided by ASHA members who have met the requirements for ASHA Certification. The proposed definition provides a description of language proficiency for clinical practice. There is an assumption that this applies not just to the provision of services in English but also to the provision of services in other languages. However, the variability in language construction and maturity—along with the influence of culture on language—may require further consideration of the applicability of all aspects of the definition and whether these aspects are equal across languages with bi-/multilingual, multicultural speakers. A number of tools are available for determining proficiency in many other languages, and there is a need to evaluate their potential for measuring proficiency for our professions. Also, there is a need for bilingual service providers to understand and address a number of other important topics that affect language—for example, dual language acquisition, contrastive analysis, and ethnographic interviewing.

The ad hoc committee should be charged with (a) determining language proficiency and related knowledge/skill requirements for service delivery in other languages and (b) recommending ways to measure competence for bilingual service delivery.

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